

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2999

FILED JAN 19 1949

State File No. 101

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE No. _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital				d. STREET ADDRESS (If rural, give location) 5230 Ridge Ave.			
3. NAME OF DECEASED (Type or Print) MICHAEL		a. (First) A. MAHER		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) Jan. 3 1949	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married		8. DATE OF BIRTH Aug. 12, 1884	
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months 4 Days 21		IF UNDER 1 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hyde Park Casino		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME William Maher		13b. MOTHER'S MAIDEN NAME Ann Fell		14. NAME OF HUSBAND OR WIFE Catherine Maher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 327-12-1123		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Catherine Maher 5230 Ridge Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paralytic Ileus - P.D. (b) Acute Peritonitis (c) Diverticulitis of Colon II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (1) Congenital diaphragmatic hernia (2) Cholelithiasis (3) Terminal Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 48 hrs 48 hrs 48 hrs	
19a. DATE OF OPERATION Dec. 28 / 48		19b. MAJOR FINDINGS OF OPERATION Stricture Sigmoid sec. to Diverticulitis and Diverticulosis				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) 5721 (COUNTY) _____ (STATE) _____		21d. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from Nov. 15, 1948, to Jan. 3, 1949, that I last saw the deceased alive on Jan. 2, 1949, and that death occurred at 7:10 A.M., from the causes and on the date stated above.							
23a. SIGNATURE Adolph L. Ramon		(Degree or title) M.D.		23b. ADDRESS 4307 W. So. Grand Blvd. St. Louis		23c. DATE SIGNED 1/4/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 7, 1949		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) St. Louis (State) Mo.	
DATE REC'D BY LOCAL REG. JAN 9 1949		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Edmund M. Burnett

Signed _____
Student Embalmer

Licensed Embalmer No. 3024

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.